Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ERGONOMIC REHABILITATION OF HOUSTON
283 LOCKHAVEN, SUITE 315
HOUSTON TX 77073

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NORTH FOREST ISD

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-11-2887-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Table of Disputed Services: "…The claim has been denied as 'based on the findings of a peer review' that we have requested four times but not ever received."

Amount in Dispute: $576.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Even though the fee schedule provides a reimbursement value for certain procedures/codes, all treatment must be medically necessary. Question number 5 on page 5 of the enclosed 07/21/10 peer review asked: What, if any, future medications, diagnostic testing, physical therapy, chiropractic treatment …would be considered reasonable, necessary and related to the compensable injury? The physician reviewer stated: 'as regards to the occupational injury, there was no evidence of any change to the body…No treatment is required as related to the 03/07/08 event'. Therefore, date of service 09/23/10 was correctly denied with the explanation based on the findings of a peer review organization."

Response Submitted by: Argus Services; 9101 LBJ Freeway, Suite 600; Dallas, TX 75243-2055

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2010	97750-FC	$ 576.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 31, 2010
   - 216A – Based on the findings of a review organization. *Peer Review*.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on April 25, 2011. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.
2. The division contacted the requestor on February 3, 2012 to determine if the disputed FCE was part of a designated doctor examination. The requestor submitted a copy of a referral request from NOVA Medical Center and a copy of a work status report check-marked with an FCE referral; however, no documentation was submitted to support that the disputed FCE was part of a designated doctor examination. Also, no documentation was submitted to support that the issue of medical necessity has been resolved as of the undersigned date.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reason concerning medical necessity has been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.